REQUEST FOR RECONSIDERATION BY MEDICAL ADVISORY COMMITTEE

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

☐ Request to advocate before the Office for Children with Special Health Care Needs (OCSHCN) Medical Advisory Committee for reconsideration for appointment to the active medical staff.

☐ Request to advocate before OCSHCN Medical Advisory Committee for reconsideration of corrective action.

Name: (Last) _____ (First) _____ (MI) __

Field of Practice _____

Office Address _____

City State Zip Code Country

Phone: _____ Email: _____

Reason/justification for reconsideration: (use back for additional space)

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_____

_____
Printed Name

_____ _____
Signature Date

Please return completed form and any supporting documentation to:

Attention: Medical Director
Office for Children with Special Health Care Needs
310 Whittington Parkway Suite 200 Louisville, KY 40222